All-Party Parliamentary Group for Ageing and Older People

Ageing in rural areas
Monday 30 January

Chair

Baroness Jolly

Speakers

David Emerson, chair, ACRE

Susan Oliver, CEO at Humber and Wolds Rural Community Council

Mervyn Kohler, Age UK

Dr Kellie Payne, Learning and Research Manager, Campaign to End Loneliness

Philip Talbot, Chief Executive, Age UK Herefordshire and Worcestershire

Dr John Miles, NHS Lancashire North CCG and University Hospitals of Morecambe Bay NHS Foundation Trust

Rural communities

The meeting heard how distance, costs and connectivity all combine to create additional challenges.

Geography was highlighted as a particularly important factor and there are differences between areas: coastal and rural areas have a higher number of older people, for example.

Community solutions like good neighbour schemes and village agents can be beneficial. They can have invaluable local knowledge and ability to support networks in a way that can overcome geographical challenges.

Connectivity

Connectivity in rural areas is very far behind the curve. This is not just a problem for older people but for everyone in those areas.

Technology keeps the system working and many technological advances would be beneficial to older people.

Driverless cars, for example, could be a boon to an ageing population who could have difficulty driving. They could particularly help in areas where public transport services are insufficient.

The meeting heard about a transport scheme in North Lincolnshire that provides door-to-door support to people in need of transport. It was personalised (not just a 'taxi service') and last year 6000 journeys were completed—this year they are already doing 30% more.

At the same time as connectivity gaps, infrastructure is struggling. For example, if a bank closes then not only does the service disappear but other businesses and services that depend on it also struggle. Older people rely on many of these community and personal services.

In health and care, there could be benefits in being able to communicate over platforms rather than needing to visit a hospital or a GP.

Sophistication will become more and more normal in our lives. Connectivity is central and rural areas are behind in this.

Loneliness

Chronic loneliness is affecting a growing number of older people, in line with the increase in the older population.

Loneliness can contribute to increased demand on health services, partly because people are more likely to develop health conditions such as heart problems, depression and dementia. At the same time, it can be particularly difficult for people with poor health to participate and this can increase the risk of loneliness.

The meeting heard from the Campaign to End Loneliness, who described how loneliness has very complex interactions. It was highlighted that loneliness is a personal issue but that living rurally can have an impact. The living environment can also amplify problems with isolation. In addition, as feelings of loneliness are based on expectation, people in rural areas may be more used to isolation and there may be more acceptance of feeling lonely.

If someone has lived in one place for longer, they have more social interaction with that area. However, if someone moves later in their life then they may not have this network.

Access to transport is vital and this is an area where policy can reduce the risk of loneliness. It can provide access to facilities and social networks. It is key to keeping people connected.

During the meeting Age UK Herefordshire and Worcestershire discussed their work on local loneliness projects.

The first, *Keep in Touch* in Ross-on-Wye, aimed to identify and help deal with problems; alleviate loneliness and isolation; and manage health and wellbeing.

The second is *Reconnections* in Worcestershire. Its goal is to reduce the cost of loneliness on the health and care system by providing a sustainable spectrum of 'reconnection' for people back in to their local communities.

The project is funded through a social impact bond, leveraging the third sector. It is the first social impact bond in England aimed at reducing loneliness and social isolation.

So far the project has had 950 referrals and 460 participants. Participants have an average age of 80 and are 70% female.

Reductions in loneliness were measured as scores and so far the project has produced constituent reductions in loneliness.

The project has also produced a number of key lessons for other schemes:

- There is a geographical dynamic to social isolation
- Community activity is 'patchy' and could be utilised more
- Social care isn't addressing loneliness
- There is more potential power in digital
- The costs of addressing the rural issue are different

Rural health and care

The meeting heard from Dr John Miles, a GP working in rural Lancashire. He shared his perspective of a GP working in a rural area and explained his work on frailty and lessons on integrating between services.

Two priorities were highlighted when integrating rural healthcare: to coordinate individuals by putting them at the focus, and to engage the community.

It was also explained that an ageing and elderly population brings two key challenges: frailty and rural social care provision.

Frailty

This was underlined as an issue that is best addressed holistically. This includes meeting unmet needs, whether they are health or problems like loneliness.

Early evidence from the work discussed at the meeting suggests a reduction in admissions and falls. It also demonstrates a need to plan care to be effective at reducing frailty.

Rural social care

The meeting heard how there are real problems around elderly patients being admitted to hospital as they are unable to be cared for at home. This also causes problems with discharge from hospital.

There is a care gap where providers are unable to provide the full package that health services would like. Care providers' resources are stretched and people are doing more individually to try and fill the gap. This leads to resources being spread further.

Councils can have difficulty raising funding in rural areas. The precept and links to business rates lead to regional differences that can have consequences for care provision.

Palliative care

Dr Miles highlighted how providers can struggle to meet demand for short term palliative care. This can be difficult to manage and patients often have to be admitted to hospital when they would prefer to be at home.

Why rural health and care is challenging

Two key ideas where suggested for why rural health and care can be so challenging:

Geography – it simply takes longer to travel from A to B and this has consequences on services

Workforce – there is not a natural care workforce in rural areas. Training and registration problems can lead to problems with staff retention

Solutions

Projects raised at the meeting had demonstrated that talking across organisations and providers can help support system wide solutions. It was emphasised that just bringing people together more can help.

Community self-care was also suggested as beneficial. Care could be provided to local people by local people on a not-for-profit basis.

Getting better at communicating patients' needs to families could also aids solutions.

Other topics discussed

Alongside the main topics of the meeting, a number of other areas were discussed by those at the meeting.

Funding

It was suggested by some that the same things are being said now as before and that the situation is no better. Money, finance and distribution is crucial, it was argued.

Other participants contended that more money alone won't change and that what matters is how that money is distributed.

It was also argued that local authority funding is having a knock-on effect on services.

Cooperation

There are still challenges around providers cooperating with services. The example of mobile phone providers sharing equipment was raised.

However, some businesses are progressing in this area and there can be a role for business in addressing many of these issues. Energy suppliers, for example, can cooperate to identify vulnerable customers and ensure that they are marked at risk through different systems. Affordable solutions like this could be replicated more widely.

The role of local services

It was suggested that reducing the scale could help with solutions and that if you look locally there can be many small changes that could help lots of older people.

GPs can have a unique role in communities: there is a social dimension to it and could be utilised within communities.

Lonely and frail people may go to a GP when they might not go to a charity or voluntary group. People may also go to GP appointments because they have no one else to talk to.

There could be a role for charities to bring people together within GP surgeries to talk to each other about their problems. This may help to reduce stigmas around problems.

Pubs can also have a similar role beyond their immediate use. They are often central geographically and socially, and can therefore act as hubs within communities. They can sometimes see when people are struggling and welcome new people into communities.

Social prescribing

The meeting heard about the use of social prescribing. Projects used local coordinators which act as one point of contact and are able to use local knowledge and local connections.

It was important that they don't just signpost people to services but that actually many needed handholding to them and to connect to the local community.

For example, helping someone with benefit checks could help them with more resources that enables them to access local services.

The project also mobilised volunteers using local coordinators. They were able to work locally and identify gaps. Social prescribing as a model was suggested as one that other organisation can easily connect around.

Key points participants suggested for Parliamentarians to take away

- More action is needed locally on prevention, whether health or issues like loneliness
- Better transport links are fundamental to improving links between people and the services they depend on – including public transport and community transport
- Older people should be consulted more services and their impact, as well as receiving more information on the benefits of technology. The infrastructure then needs to support them
- More local engagement is needed with communities in health and care
- The role of local services is crucial—they can provide benefits beyond their immediate use (eg pubs acting as community hubs)
- Every community has it within them to address needs – there should be more trust from senior managers to empower community champions in health and care
- The voluntary sector wants to support projects and should be supported to do so